much of this sports-related tobacco advertising appears to be directed at youth. Some communities have responded with parodies such as the "Emphysema Slims Tennis Tournament" and the "Dead Man Chew Softball Tournament." Others have used paid counteradvertising on television, radio, billboards, and bus benches to tell the truth about tobacco and to point out the insidious techniques used in its promotion.

These new approaches for preventing tobacco abuse by children have been pioneered by DOC. The American Medical Association, the American Academy of Family Physicians, and the American Cancer Society are all beginning to adopt these new methods, while continuing their efforts to encourage smoking cessation.

Through counteradvertising and tobacco education programs on the local and national levels, it may be possible to reduce the number of new smokers and thereby decrease the impact of the tobacco-related diseases that presently kill 1,000 Americans every day.

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REFERENCES

The Health Consequences of Smoking: Report of the Surgeon General. US Dept of Health, Education, and Welfare, Public Health Service, Centers for Disease Control, 1988

The World Cigarette Pandemic. NY State J Med 1983 Dec (special issue [available as Blum A (Ed): The Cigarette Underworld, Secaucus, NJ, Lyle Stuart, 1985])

Tobacco and Youth Reporter, STAT (Stop Teenage Addiction to Tobacco), PO Box 50039, Palo Alto, CA 94303

Diarrhea in Children

FOR MANY CLINICIANS, the treatment of diarrhea is straightforward: the patient is not given anything orally while the intravenous (IV) administration of fluids is started, then the patient is given clear liquids for 24 to 48 hours, followed by a BRAT—bananas, rice, applesauce, toast—diet. Recent studies, primarily in third-world populations, have shown that this is not the optimal therapy.

Perhaps the biggest change has been in IV fluids therapy, which is now recognized as rarely necessary. Instead, oral rehydration solutions—World Health Organization Oral Rehydration Solution (WHO ORS), Pedialyte, Lytren—are available and effective in replacing lost fluids. It should be emphasized that many "clear liquids" such as soft drinks and popsicles are not ideal therapies: they are low in sodium and potassium, key electrolytes in this disease state, and high in carbohydrates, a fact that may prolong the diarrhea. If soft drinks or fruit juices are used, they should be diluted one part beverage to two parts water because they are hyperosmolar and may draw water into the lumen. In addition, commercially prepared soup (high in salt content) and tap water (no electrolytes) should not be a major component of the therapy. For these reasons, many clear liquids should be avoided, except in limited quantities or in mild cases.

Because continued breast-feeding is beneficial, there is a growing thought that the disease state responds better to the additional nutrition than to starvation. In underdeveloped countries where no IV fluids are available and the WHO ORS formula is widely used, research has shown that replacing the glucose in the oral rehydration solution with rice powder or protein actually decreases the recovery time. Recent studies in England and the United States have confirmed these findings. Thus, the trend is now to give oral clear liquids (as described above) in the first few hours of illness followed by early feeding of a carbohydrate-protein-electrolyte mixture while the patient still has diarrhea. This regimen is thought to be not only safe but preferred because it decreases morbidity and costs.

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REFERENCES

Ghishan FK: The transport of electrolytes in the gut and the use of oral rehydration solutions. Pediatr Clin North Am 1988; 35:35-51

Hamilton JR: Viral enteritis. Pediatr Clin North Am 1988; 35:89-101

Santosham M, Foster S, Reid R, et al: Role of soy-based, lactose-free formula during treatment of acute diarrhea. Pediatrics 1985; 76:292-298

Circumcision Reevaluated

DESPITE BEING THE MOST COMMON surgical procedure in the country, circumcision has been the center of tremendous and often intense debate for the past 40 years. So adamant have the two camps been that little consensus has been achieved. Thus, though the American Academy of Pediatrics is reevaluating its 18-year-old anticircumcision stance, it is unlikely the controversy will be resolved. Though there are currently no answers, family physicians should be updated on the debate in order to better inform parents and to assist in the needed research.

Central to the debate is the evaluation of health risks and benefits. Most health risks of remaining uncircumcised—balanitis, posthitis, penile cancer, phimosis, and foreskin trauma—are too insubstantial in frequency or morbidity to play a role in decision making. The recently discovered tenfold increase in urinary tract infections in uncircumcised persons has swayed many to favor the procedure, but the long-term effects of this increased risk are not known. In addition, the original belief that the procedure is "harmless" in most infants has come into question with the recent realization that neonates do feel pain and show pronounced physiologic and biochemical changes to this pain.

What role, then, does the family physician have? It is clear there is no consensus, and the field is evolving. To strongly adhere to one belief or the other is probably unwise. Until such time that the several questions regarding circumcision and the uncircumcised state are answered, supportive counseling of parents is the best plan.

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REFERENCES

Nasrallah PF: Circumcision: Pros and cons. Primary Care 1985; 12:593-605

Wallerstein E: Circumcision—The uniquely American medical enigma. Urol Clin North Am 1985; 12:123-132

The Melanoma Epidemic

ALTHOUGH THE EPIDEMIC of disease mediated by the human immunodeficiency virus has rightfully taken much of our attention, primary care physicians must not forget that we are also in the midst of an epidemic of malignant melanoma. The incidence of malignant melanoma roughly tripled between 1950 and 1970 and has increased by 700% over the past 55 years. It is estimated that by the turn of the century malignant melanoma might well afflict 1% of the general American population.

It is extremely important that primary care physicians be trained to diagnose malignant melanoma in its early stages because prognosis is best correlated with the thickness of the lesion. The relationship of melanoma thickness to five-year survival is as follows: 0 to 0.85 mm, 99%; 0.86 to 1.69 mm, 94%; 1.70 to 3.59 mm, 81%; and 3.60 mm or larger, 49%.

Definite risk factors for melanoma include white race, particularly those of Celtic heritage; sun exposure, particularly with episodes of sunburn; dysplastic nevi, particularly familial dysplastic nevi; and large congenital nevi (greater than 20 cm).

Patients should be encouraged to report any change in a skin lesion, particularly recent growth, bleeding, pain, or the development of a new lesion. Physicians should remove or take a biopsy of any skin lesion that is at all suggestive of melanoma.

Physicians should be vigilant in screening for melanoma and should keep in mind the rule of "ABCD": *A*symmetry, *B*order irregularity, *C*olor variegation, and *D*iameter generally greater than 6 mm. Various textbooks and monographs are available to assist physicians in recognizing melanoma in its earliest stages.

The familial dysplastic nevus syndrome is an autosomal dominant condition with a lifetime incidence of melanoma approaching 100%. Dysplastic nevi tend to be more plentiful (25 to 75 per person) and larger (6 to 15 mm) than common nevi. Dysplastic nevi are acquired after birth and often have irregular borders, variegated colors (particularly tan, brown, and pink), and indistinct borders fading into the adjacent normal skin.

Primary prevention includes avoiding sunlight, using protective clothing and hats, and using sunscreens as early as infancy and throughout adult life. Sunbathing and the use of tanning parlors should be actively discouraged. The melanoma epidemic is presenting all primary care physicians with the challenge of the primary prevention of the disease and the early detection of melanoma at a time when it is completely curable.

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REFERENCES

Greene MH, Clark WH, Tucker MA, et al: Acquired precursors of cutaneous malignant melanoma: The familial dysplastic nevus syndrome. N Engl J Med 1985; 312:91-116

Rigel DS, Fridman RJ (Eds): Dermatologic Clinics: Symposium on Melanoma and Pigmented Lesions, Vol 3. Philadelphia, WB Saunders, 1985

Silent Myocardial Ischemia

ALTHOUGH MYOCARDIAL ISCHEMIA AND INFARCTION are major health problems in the western world, our understanding of this disease remains incomplete. Physicians think of ischemic heart disease as a clinical syndrome manifested by chest pain or other "anginal equivalents." The cardiologic literature over the past decade has clearly shown, however, that silent myocardial ischemia is a common manifestation of coronary artery disease. In fact, there is every reason to think that silent myocardial ischemia carries the same (or worse) clinical significance as symptomatic coronary artery disease. This should come as no surprise because one of five sudden death victims in the United States has no history of heart disease, yet commonly has evidence of advanced arteriosclerotic disease in the coronary arteries at autopsy.

Silent myocardial ischemia has been studied predominantly using two tools: ambulatory Holter electrocardiographic monitoring and the exercise test. Although factors that make myocardial ischemia painless in some persons are not completely understood, it is a common phenomenon. In a study of patients with angina with known coronary artery disease documented by arteriography, 75% of all ambulatory episodes of ischemia were painless. Silent myocardial ischemia shares the same circadian variations as angina pectoris and myocardial infarction, occurring most often in the morning, generally between 0600 and 1200. Silent myocardial ischemia, however, seems to develop more commonly at rest and at lower levels of heart rate and blood pressure. This suggests, but does not prove, that silent myocardial ischemia may be due to enhanced coronary artery vasoconstriction, as opposed to an increase in myocardial oxygen demand.

Although it is becoming clear that the problem of silent myocardial ischemia is one of major proportions, the solution is less clear. Cohn recommends screening exercise tests in all patients with two or more major risk factors for coronary artery disease, particularly those with diabetes mellitus because of visceral neuropathy. Patients with abnormal results on treadmill tests, but ST depression less than 2 mm in stage I or II of the Bruce protocol, should have radionuclide imaging. The decision to proceed to coronary arteriography depends on the patient. In general, patients suffering a myocardial infarction undergo exercise testing, usually at least two to three weeks after the infarction. Silent myocardial ischemia in patients with stable angina pectoris is often best detected by ambulatory Holter monitoring.

Currently there is no reason to treat silent myocardial ischemia any differently than symptomatic angina pectoris. Risk factors should be modified to the extent possible. The decision to proceed to arteriography and ultimately angioplasty or coronary artery bypass grafting must be tailored to each patient. In patients who have suffered a myocardial infarction and subsequently show silent myocardial ischemia, many data suggest a long-term benefit with β-blocker therapy. Patients with angina pectoris and silent myocardial ischemia are subject to vasospasm and therefore may benefit from using calcium channel blockers, as well as nitrates and β-blockers.

In the forthcoming years, much new information will surface regarding silent myocardial ischemia. Because of the extent of this public health problem, primary care physicians should make every effort to keep abreast of new developments in the diagnosis and treatment of the disorder.

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REFERENCES

Cohn PF: Silent myocardial ischemia. Ann Intern Med 1988; 109:312-317

Cohn PF, Kannel WB: Recognition, pathogenesis, and management options in silent coronary artery disease: Introduction. Circulation 1987; 75 (pt 2):II1

Fluoroquinolones

THE FLUOROQUINOLONES are a remarkable new group of bactericidal antibiotics related to nalidixic acid. Among other effects, they appear to act on DNA gyrase, an enzyme involved in DNA replication. The agents currently available in the United States include norfloxacin and ciprofloxacin. Because these agents show a wide spectrum of bactericidal activity and an apparently excellent safety profile, they can be extremely effective agents in a primary care practice but must be used wisely.

The spectrum of antibacterial activity of these agents includes *Escherichia coli, Klebsiella, Hemophilus influenzae* (including ampicillin-resistant strains), meningococci, *Branhamella catarrhalis, Salmonella, Shigella, Campylobacter jejuni, Aeromonas, Yersinia enterocolitica,* staphylococci (including methicillin-resistant *Staphylococcus aureus*), and *Pseudomonas aeruginosa.*

Norfloxacin and ciprofloxacin have been shown to be effective for the treatment of genitourinary and gastrointes-